

Please complete using black ink or typewriter. Return signed and completed application — and those of employees — to your broker.

Group #

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(for CHOICE Administrators® staff use only)

A. Employer Information

1. Legal Company Name:			2. Date Business Started: / /			3. CA Federal Tax ID # (9 digits)—NOT Social Security # -					
4. DBA Name (Doing Business As):				5. Exact Nature of Business:				6. Owner/President Name:			
7. Company Structure: <input type="checkbox"/> Corporation <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> LLC <input type="checkbox"/> S Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Other _____						8. Contact Name:					
9. Contact Job Title:			10. Contact Phone: ()			11. Contact Fax: ()			12. Contact E-mail:		
13. Billing Address Street:			Suite/Unit #:		City:		State:		Zip:		Check if Residence <input type="checkbox"/>
14. Street Address (if different) (no P.O. Box) Street:			Suite/Unit #:		City:		State: CA		Zip:		Check if Residence <input type="checkbox"/>
15. Workers' Comp Carrier Name: (not broker or agency name)				16. Policy #:				17. Future Renewal Date: (mo/day/year) / /			
<p>Note: Workers' Compensation Coverage must be effective on or prior to the effective date requested with Kaiser Permanente Choice Solution</p>											
<p>18. <input type="checkbox"/> We are not covered by Workers' Compensation coverage due to legal exemption under the following checked condition:</p> <p><input type="checkbox"/> Corporation: 100% owners/shareholders (Corporation must be closed and officers must be owners and own all stock)</p> <p><input type="checkbox"/> LLC/Partnership: 100% owners/partners (General partnership must be set up as a Corporation with all partners as owners)</p> <p><input type="checkbox"/> 100% family-related running business out of home (does not include domestic partners; family members must reside at the same residence)</p>											

B. Enrollment & Eligibility Information

1. Requested effective date: (mo/day/year) / /			
2. Have you employed 20 or more employees during at least 50% of the preceding calendar year? (COBRA) <input type="checkbox"/> Yes <input type="checkbox"/> No			Total # of COBRA enrollees:
3. If you answered YES to question #2, do you want your COBRA participants on your bill? (If yes, you must complete the "Group COBRA Direct Billing" contract) <input type="checkbox"/> Yes <input type="checkbox"/> No			
4. Have you employed 20 or more employees for 20 or more weeks during the current or preceding year? (TEFRA) <input type="checkbox"/> Yes <input type="checkbox"/> No			
5. Does your group currently have group medical coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	Carrier Name:	Policy #:	Termination Date: / /
6. Is your group wrapping with another carrier? <input type="checkbox"/> Yes <input type="checkbox"/> No	if yes, provide carrier name:		
7. Have you had Kaiser coverage within the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please provide your most current Risk Adjustment Factor (RAF):		
8. Eligible employees must work the following number of hours to qualify: <input type="checkbox"/> 20+ hours a week <input type="checkbox"/> 30+ hours a week			
9. Waiting Period: all new employees and their dependents will be eligible for coverage <u>the first of the month following:</u> <input type="checkbox"/> Date of Hire <input type="checkbox"/> 30 days <input type="checkbox"/> 60 days <input type="checkbox"/> 90 days <input type="checkbox"/> 180 days <input type="checkbox"/> 365 days <small>(Other options are not available, please do not write in)</small>			
10. Waiting period applies to: <input type="checkbox"/> Future employees (hired after the effective date) <input type="checkbox"/> Current and future employees (Current=hired on or prior to effective date)			# in Waiting Period
11. Total number of employees on payroll regardless of hours worked: _____ (including owners, seasonal, etc.) Total number of <u>active eligible</u> employees on payroll: _____ (including owners and partners) Total number of eligible employees <u>applying</u> for medical: _____ (including owners and partners)			
12. Number of employees waiving due to: A) Other Group Coverage _____ B) Other Individual Coverage _____			
13. Total number of <u>ineligible</u> employees in each of the following categories: (write "0" if none) A) Union: _____ B) Part-time: _____ C) Seasonal: _____ D) Temporary: _____ E) Terminated: _____			
14. How many of the employees (including owners) enrolling are related by blood or marriage? _____			

C. Premium Contribution Method

NOTE: Employer must pay for at least 50% of each employee's lowest cost premium.

*Dependent contributions are optional for Employer.

CHOOSE ONLY ONE OPTION BELOW:

OPTION 1 **PERCENTAGE OF COST**

STEP 1: Enter the percentage amount you will contribute toward:

Employee Premium: _____% (50% minimum required) *Dependent Premium: _____% (write 0 if none)

STEP 2: Apply contribution toward one HMO, POS, PPO, Indemnity, HDHP* or ANY Plan Option (A, B, C, D, E or F)

A. HMO 10 HMO 30 HMO 20/\$1000

B. POS 20/\$1000 POS 30/\$1500

C. PPO 30/\$500 PPO HSA 2200*

D. Indemnity

E. HDHP 1900* HDHP 2700*

F. Any plan selected by employee

*HSA-Qualified High Deductible Health Plan

OPTION 2 **EMPLOYER FIXED DOLLAR AMOUNT**

Enter the dollar amount(s) you will contribute toward any plan selected by the employee:

\$ _____ for Employee

OR

\$ _____ Combined amount for Employee and *Dependents

\$ _____ for *Dependents

Please be advised that Employee Enrollment Application forms are available in the following languages: Spanish, Vietnamese and Chinese - please contact your broker or Kaiser Permanente Choice Solution. Some translations in these languages are also available to your employees on an on-going basis as well as interpretation services in 150 different languages. Kaiser Permanente Choice Solution would be glad to give you copies of the Employee Enrollment Application Form in the "threshold languages" of the Plan(s) your employees select. Please contact us or your broker to receive these.

To be completed by BROKER:		General Agent/PPGA Name: (if applicable)	
Broker Name (please print) Must be broker name—not agency		Co-broker name (please print)	
Phone: ()	Fax: ()	Phone: ()	Fax: ()
Commissions payable to:	% Commission if split:	Commissions payable to:	% Commission if split:
<i>I certify that the employer applying for coverage through the Kaiser Permanente Choice Solution Program has met the 70% participation requirement</i>			
Broker signature:		Co-broker signature:	

D. Statement of Compliance

I hereby certify that all the information contained in the employer and employee applications are true and correct to the best of my knowledge. I have read and understand the following statements and confirm that my group complies with all the rules and regulations of the Kaiser Permanente Choice Solution Program. I understand that no coverage will become effective until notified by the Kaiser Permanente Choice Solution Underwriting Department.

- Must have an office located in California.
- A majority (51+%) of our eligible employees live or work in California.
- I will maintain 70% participation including all eligible employees.
- Kaiser Permanente Choice Solution coverage will be offered to all eligible employees on a uniform basis for those working 20+ hours/week.
- All employees enrolling are currently working the minimum number of hours per week to be considered eligible to enroll for Kaiser Permanente Choice Solution coverage.

I understand that once Kaiser Permanente Choice Solution coverage is approved, group policy changes cannot be implemented until the next Renewal period. These changes shall include, but are not limited to COBRA provisions, new hire waiting period, minimum hours worked per week, and premium contribution amounts.

I understand that once membership information is transmitted to the elected health plans, our group coverage effective date cannot be changed nor can our coverage be terminated until after the first month of coverage.

I understand that no alterations can be made to this section and that it must be signed exactly as stated.

I understand that the above statements are subject to audit at any time.

I understand that the above qualifications must be maintained in order for my group to continue coverage through Kaiser Permanente Choice Solution.

I agree to provide CHOICE Administrators® with any and all information necessary to prove the above statements.

I understand that if I am unable to provide the requested information, all Kaiser Permanente Choice Solution benefits will terminate 15 days following notice of termination, and employees will be held responsible for all services and charges incurred through Kaiser Permanente Choice Solution program providers.

I understand that any persons, business, or health plan that suffers a loss because of false declarations contained in this Employer Application may have cause to bring civil action against our company to recover their losses.

I understand that Small Business deductible plans, except designated HRA plans, are sold as stand-alone plans and are not to be used in conjunction with self-funding arrangements, such as wrapping (or self-funding) member expenses either directly or through a third-party administrator (TPA). My company may make contributions to health savings accounts (HSAs), but not as a member-expense reimbursement mechanism where the consumer-directed aspect of consumer directed health plans (CDHPs) is lost.

I understand that premium payments are to be received by Kaiser Permanente Choice Solution by the statement due date and if payment is not received by the due date, my group will be subject to a 10% late fee.

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if my Group must comply with ERISA, certain benefit-related disputes) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Health Plan, its health care providers, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in Health Plan, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the Evidence of Coverage.

I DECLARE UNDER THE PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT THE ABOVE STATEMENTS ARE TRUE AND CORRECT.

Owner/Partner Signature _____ Print Name _____ Date _____

Company Name _____

Witness Signature of Broker of Record _____ Print Name _____ Date _____

E. Medical Questionnaire (15 or more medically enrolling employees*)

The Employer must answer the following questions to the best of his/her knowledge for all eligible employees, proprietors, partners, corporate officers, COBRA participants and all eligible dependents, including spouses & domestic partners to be enrolled.

1. Is any employee to be covered not actively at work performing his or her full-time duties or missed five or more days in the last two months due to injury or illness? YES NO

Provide name(s) of employee(s) not actively at work: _____
(write "NA" if none)

2. Has anyone been treated for a serious illness, been hospitalized, had surgery or incurred medical expenses in excess of \$5000 during the past 5 years? YES NO

If "yes" please enter reason: _____

3. Is anyone currently being treated or been advised to seek treatment for cancer, chest pain, heart disease, stroke, high blood pressure, kidney disorder, liver disease, birth defects, transplants, brain tumor, nervous system disorders, diabetes, AIDS, AIDS Related Complex, Chronic respiratory disease, alcoholism, chemical dependency, mental disorder, depression or any other serious conditions? If "yes" please circle condition(s) YES NO

4. Is anyone currently pregnant? YES NO
If "yes" how many? _____

* **IMPORTANT:** Employees must complete an individual Health Questionnaire if less than 15 employees are medically enrolled. (COBRA participants are not counted as employees.)

Optional Benefits Application GROUP NAME: _____

F. Dental Insurance

DeltaCare® USA (DHMO)/Delta Dental (PPO & FFS)

Complete numbers 1-6

1. Total number of employees applying for dental coverage: _____
2. Total number of COBRA eligibles applying for dental coverage: _____
3. Percentage of employee-only premium paid by Employer: _____ % *(Employer must pay a minimum of 50%)*
4. Percentage of dependent premium paid by Employer: _____ % *(write 0 if none)*
5. Employer contribution is based on plan: DHMO 200 DHMO 250 PPO/FFS 1000 PPO/FFS 1500
6. Does your group currently have dental? Yes No If yes, carrier name: _____

G. Life Insurance

AIG Employee Benefit Solutions

Requirements: 100% of eligible employees must participate. Employee Enrollment Applications (**Form KP 0310***) must be submitted by each employee with Sections A, D (life portion) and E completed.

Products underwritten by AIG Life Insurance Company
Wilmington, DE
A member company of American International Group, Inc.
Policy Form Series G-LAD-40000 et al.

CHOOSE EITHER OPTION 1 OR OPTION 2

OPTION 1: Flat Amount
Select a Flat amount for all employees:

1.. Amount \$:

2. # of eligible employees:

Guaranteed Issue Amounts available for both Options		
Eligible Employees	Minimum	Maximum
2-9	\$10,000	\$25,000
10-24	\$10,000	\$50,000
25-50	\$10,000	\$75,000
Amounts in between available in increments of \$5000		
100% of all eligible employees (whether enrolling or waiving medical) must enroll for life coverage.		
*Employees must fall under classification to qualify for specified amount →		

OPTION 2: Scheduled Amount
Select up to 4 amounts with the highest being NO MORE THAN 2.5 X the lowest.
(highest amount ok in increments of \$5000)

Life Amount	Employee Classification* <i>(i.e. management, administrative, etc.) Specific job titles will be required for each class</i>
\$ _____	_____
\$ _____	_____
\$ _____	_____
\$ _____	_____

H. Section 125—Premium Only Plan

CONEXIS Benefit Administrators

***A one time \$100 Enrollment Fee must be submitted with the premium deposit**

1. Name of Company President, Principal, or Partners: _____
2. Name of Corporate Secretary: (if applicable) _____
3. Plan Number: _____ (usually 501)
4. State of Incorporation (if applicable): _____
5. Company Structure:
 Corporation S Corporation Partnership Sole Proprietorship LLC Other _____
6. Premium payments may be elected for: Medical Dental Vision Other: _____
7. Last day of first Plan year: _____ / _____ / _____ (Approximately 364 days after the effective date of coverage)
Subsequent plan years will be the 12 month period following this date.

Participation Limitations

P.O.P. rules require that all participants in the plan be employees. Please be advised that 2% (or greater) shareholders in an S-Corporation, Sole Proprietors in a Sole Proprietorship and Partners in a Partnership are not considered employees as defined by Tax Code, and therefore, are ineligible to participate in the P.O.P.

IMPORTANT: Read the information provided in the Kaiser Permanente Choice Solution Employer Optional Benefits Guide pertaining to the Section 125 Premium Only Plan and the tax consequences.

Employer Signature: _____

Print Name _____

Date _____